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## **Change in the Determination of the Prescription Count for Global Limits, the FORM and Recipient Opt-In Programs**

Effective January 1, 2008, the N.C. Division of Medical Assistance (DMA) will count only unique, unduplicated prescriptions when counting prescriptions for Global Limits, the FORM and Recipient Opt-In programs. Duplicate prescriptions filled during the month, for example early refills, will no longer be included in the monthly prescription counts. Duplicate prescriptions are defined as prescriptions that have the same GCN sequence number (same drug, strength and dosage form) as a previously filled prescription within the same calendar month.

DMA will continue to systematically review recipients who have opted into a pharmacy under the FORM and Recipient Opt-In programs and automatically remove them from both programs when fewer than 12 prescriptions have been dispensed in two out of the last three months or when fewer than 12 prescriptions have been dispensed in the sixth month. With this change, some recipients who have qualified for the FORM and Recipient Opt-In programs in the past may no longer qualify for either of these programs.

## **Procedures for Prescribing Synagis for 2007–2008 Respiratory Syncytial Virus Season are Revised to Include EPSDT information**

The procedure announced in the September 2007 North Carolina General Medicaid Bulletin and October 2007 North Carolina Pharmacy Newsletter is revised to include information about Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). Synagis is administered under Medicaid's Outpatient Pharmacy Program. Therefore, all administrative policy requirements, including EPSDT, found in this policy apply to Synagis administration. While the Synagis procedure outlined in the publications identified below is consistent with currently published American Academy of Pediatrics RedBook guidelines (on the web at <http://aapredbook.aappublications.org/cgi/content/full/2006/1/3.107>-subscription required) or in RedBook: 2006 Report of the Committee on Infectious Diseases—27<sup>th</sup> edition, it is important to note that:

1. The decision to approve or deny a request for Synagis that exceeds the guidelines specified in the above publications will be based on the recipient's **MEDICAL NEED** to correct or ameliorate a defect, physical [or] mental illness, or condition [health problem]. "Ameliorate" means to improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.
2. The specific coverage criteria (e.g., particular diagnoses, signs, or symptoms) specified in the above publications do **NOT** have to be met for recipients under 21 years if medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problems]. For these recipients, the Request for Medical Review for Synagis Outside of Criteria form is used to request Synagis.
3. The specific numerical limits (number of hours, number of visits, or other limitations on scope, amount or frequency, age of the recipient) specified in the above publications do **NOT** apply to recipients under 21 years of age if **MEDICALLY NECESSARY** to correct or ameliorate a defect, physical or mental illness, or

condition [health problem]. Under EPSDT, Synagis (like any other Medicaid service) may be prescribed as often as needed for any Medicaid recipient under age 21 if it is medically necessary to correct or ameliorate the recipient's health problem.

4. Other restrictions specified in the publications above may be waived under EPSDT as long as exceeding those restrictions is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

For further information about EPSDT, see the August 2007 EPSDT Policy Instructions Update at the website specified below.

<http://www.dhhs.state.nc.us/dma/EPSDT/EPSDTPolicyInstructionsUpdate081707.pdf>

### **Submitting the Request for Medical Review Form**

When a recipient does not meet the guidelines published in the Synagis procedure but the provider still wishes to prescribe Synagis, submit the Request for Medical Review for Synagis Outside of Criteria Form by doing the following:

1. Prescriber completes the form, including the medical necessity justification, signs it, and faxes it to DMA at (919) 715-1255. This is the only form that prescribers should fax to DMA.

\*The Request for Medical Review for Synagis Outside of Criteria Form is found at <http://www.ncdhhs.gov/dma/Forms/SynagisMedicalReview.pdf>

2. The request will be reviewed and either approved or denied. Notification of the result will be sent to prescribers.
3. Pharmacy distributor maintains a copy of the approval letter on site.

Justification documentation must clearly address how exceeding policy limits will correct or ameliorate (improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems). Should additional information be required, the provider will be contacted.

**Note:** Processing delays can occur if the recipient does not have a Medicaid identification number or the form is not complete.

### **Additions to OTC Coverage List**

There have been numerous OTC's added to the OTC coverage list for reimbursement by N.C. Medicaid in conjunction with a prescription order by the physician. The updated list will be available by December 1, 2007 and is located in the General Clinical Policy No. A-2 on DMA Web site: <http://www.dhhs.state.nc.us/dma/APA/A2.pdf>.

## **National Provider Identifier and Address Information Database**

In the later part of November 2007, the Division of Medical Assistance (DMA) will implement a searchable National Provider Identifier (NPI) and address database. Providers can access the database by NPI or Medicaid provider number, at <http://www.ncdhhs.gov/dma/NPI.htm>. Please access the database as soon as possible to verify your NPI, site address, and billing address. If all information is correct, no action is necessary. To correct typographical errors: print the form, make corrections, and fax to the number on the printable form. To correct more serious (non-typographical) errors, submit a Provider Change Form (<http://www.ncdhhs.gov/dma/Forms/changeprovstatus.pdf>) and include any other applicable documentation.

## **National Provider Identifier to Replace Drug Enforcement Administration Number on Claims**

Currently, the prescribing provider's Drug Enforcement Administration (DEA) number is used as an identifier on pharmacy claims. Upon National Provider Identifier (NPI) implementation, the NPI will replace the DEA number. Pharmacists are encouraged to begin requesting the NPIs of prescribing providers. Some providers have elected to add their NPIs to their prescription pads. Prescribing providers need to share their NPIs with pharmacies, as it will be required for pharmacy claims processing.

Once the transition takes place in May 2008, if the prescriber's NPI is not on the claim, the pharmacy claim will be denied with EOB 3105, which states, "The NPI submitted for the prescribing provider is missing or invalid." The pharmacy will then need to verify the prescriber's NPI and resubmit the claim.

These policies supersede previously published policies and procedures. Providers may contact EDS at 1-800-688-6696 or 919-851-8888 with billing questions.

## **Payment Error Rate Measurement in North Carolina**

In compliance with the Improper Payments Information Act of 2002, the Centers for Medicare and Medicaid Services (CMS) implemented a national Payment Error Rate Measurement (PERM) program to measure improper payments in the Medicaid program and the State Children's Health Insurance Program (SCHIP). North Carolina has been selected as one of 17 states required to participate in PERM reviews of claims paid in Federal fiscal year 2007 (October 1, 2006 – September 30, 2007).

CMS is using three national contractors to measure improper payments. One of the contractors, Livanta LLC (Livanta), will be communicating directly with providers and requesting medical record documentation associated with the sampled claims (approximately 800 - 1200 claims for North Carolina). Providers will be required to furnish the records requested by Livanta, within a timeframe indicated by Livanta.

**It is anticipated that Livanta will begin requesting medical records for the NC sampled claims this month. Providers are urged to respond to these requests promptly with timely submission of the requested documentation.**

Providers are reminded of the requirement in Section 1902(a)(27) of the Social Security Act and Federal Regulation 42 CFR Part 431.107 to retain any records necessary to disclose the extent of services provided to individuals and, upon request, furnish information regarding any payments claimed by the provider for rendering services.

## **Tax Identification Information**

The N.C. Medicaid program must have the correct tax information on file for all providers. This ensures that 1099 MISC forms are issued correctly each year and that correct tax information is provided to the IRS. Incorrect information on file with Medicaid can result in the IRS's withholding 28% of a provider's Medicaid payments. The individual responsible for maintenance of tax information must receive the information contained in this article.

### **How to Verify Tax Information**

The last page of the Medicaid Remittance and Status Report (RA) indicates the tax name and number on file with Medicaid for the provider number listed. Review the Medicaid RA throughout the year to ensure that the correct tax information is on file for each provider number. If you do not have access to a Medicaid RA, call EDS Provider Services at 919-851-8888 or 1-800-688-6696 to verify the tax information on file for each provider.

### **How to Correct Tax Information**

All providers are required to complete a W-9 form for each provider for whom incorrect information is on file. Please go to the following to obtain a copy of a W-9 form <http://www.irs.gov/pub/irs-pdf/fw9.pdf>. Correct information must be received by December 01, 2007. The procedure for submitting corrected tax information to the Medicaid program is outlined below:

All providers who identify incorrect tax information must submit a completed and signed W-9 form, along with a completed and signed Medicaid Provider Change form or Carolina ACCESS Provider Information Change Form, to the address listed below:

Division of Medical Assistance - Provider Services  
2501 Mail Service Center  
Raleigh NC 27699-2501

## **False Claims Act Education**

Effective January 1, 2007, Section 6023 of the Deficit Reduction Act (DRA) of 2005 requires providers receiving annual Medicaid payments of \$5 million or more to educate employees, contractors, and agents about Federal and State fraud and false claims laws and the whistleblower protections available under those laws.

Beginning September 2007 and annually thereafter, the North Carolina Division of Medical Assistance (DMA) will notify providers that they received a minimum of \$5 million dollars in NC Medicaid payments during the last federal fiscal year and that they must submit a Letter of Attestation to show that they are in compliance with the DRA. This minimum amount may have been paid to one NC Medicaid provider number or to multiple provider numbers associated with the same tax identification number. Each NC Medicaid provider who receives a notification

letter must download a copy of the Letter of Attestation from the DMA Web site and print, sign, and mail it to EDS within 30 days of the date of notification. Downloadable Letter of Attestation forms and a complete list of NC Medicaid provider numbers identified as having received the minimum amount of NC Medicaid payments can be found on our Web site at <http://www.ncdhhs.gov/dma/fca/falseclaimsact.html>.

Compliance with Section 6023 of the DRA is a condition of receiving Medicaid payments. Medicaid payments will be denied for providers that do not submit a signed Letter of Attestation within 30 days of the date of notification. Providers may resubmit claims once the signed Letter of Attestation is received.

By November 1, 2007, provider enrollment application packets were to be submitted to DMA with a signed Letter of Attestation. An enrollment application packet is considered received by DMA when it is current, complete, original, and signed.

### **Clinical Coverage Policies**

The following new or amended clinical coverage policies are now available on the Division of Medical Assistance's Web site at <http://www.ncdhhs.gov/dma/mp/mpindex.htm>:

- [1A-23, Physician Fluoride Varnish](#)
- [1F, Chiropractic Services](#)
- [9, Outpatient Pharmacy Program](#)

### **Proposed Clinical Coverage Policies**

In accordance with Session Law 2005-276, proposed new or amended Medicaid clinical coverage policies are available for review and comment on DMA's Web site at <http://www.ncdhhs.gov/dma/prov.htm>. To submit a comment related to a policy, refer to the instructions on the Web site. Providers without Internet access can submit written comments to the address listed below.

Loretta Bohn  
Division of Medical Assistance  
Clinical Policy Section  
2501 Mail Service Center  
Raleigh NC 27699-2501

### **Reaching Compliance with HIPAA Privacy Regulations**

The information sent through the North Carolina Medicaid e-mail system is considered public information and is not encrypted. The security of patient information sent by e-mail cannot be guaranteed. If it is necessary to send patient specific information to an "ncmail.net" or "eds.com" e-mail address, please send the information in a password-protected attachment to the e-mail. Telephone the e-mail recipient with the password; do not send it by e-mail.

Examples of information that should be protected include any protected health information (PHI), as defined by the HIPAA Privacy Rule [such as the patient's full name, Medicaid ID Number (MID), Internal Control Number (ICN), Prior Approval Number (PA#)]. When the need to reference particular claims and/or other items arises, we recommend the use of the last four digits of the ICN and the billed amount, or the billed amount and the recipient's initials, and similar tactics. This will allow DMA and/or its fiscal agent to determine which claim is being referenced without explicitly using PHI to do so. See <http://www.ncdhhs.gov/dma/hipaa/submitpatientinfo.html> for additional information

## Changes in Drug Rebate Manufacturers

The following changes are being made in manufacturers with Drug Rebate Agreements. They are listed by manufacturer code, which are the first five digits of the NDC.

### Additions

The following labelers have entered into Drug Rebate Agreements and have joined the rebate program effective on the dates indicated below:

<i><b>Code</b></i>	<i><b>Manufacturer</b></i>	<i><b>Date</b></i>
25010	Aton Pharma. Inc.	10/22/2007
31722	Camber Pharmaceuticals, Inc	10/03/2007

### Voluntarily Terminated Labelers

The following labelers requested voluntary termination effective October 1, 2007:

Laser Pharmaceuticals, LLC.	(Labeler 64860)
PediaMed Pharmaceuticals, Inc	(Labeler 96346)

The following labelers have requested voluntary termination effective January 1, 2008:

Elan Pharmaceuticals, LLC.	(Labeler 00086)
Stada Pharmaceuticals, Inc.	(Labeler 55370)
Stada Pharmaceuticals, Inc.	(Labeler 64860)

## Checkwrite Schedule

November 06, 2007	December 04, 2007	January 08, 2008
November 14, 2007	December 11, 2007	January 15, 2008
November 21, 2007	December 20, 2007	January 24, 2008

## Electronic Cut-Off Schedule

November 01, 2007	December 06, 2007	January 03, 2008
November 08, 2007	December 13, 2007	January 10, 2008
November 15, 2007		January 17, 2008
November 29, 2007		January 31, 2008

*Electronic claims must be transmitted and completed by 5:00 p.m. on the cut-off date to be included in the next checkwrite. Any claims transmitted after 5:00 p.m. will be processed on the second checkwrite following the transmission date. POS claims must be transmitted and completed by 12:00 midnight on the day prior to the electronic cut-off date to be included in the next checkwrite.*

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